NHS Greater Glasgow and Clyde

NHS GG&C Mental Health Service

Suicide Reduction Guidance

Important Note:
The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Document Number:	**MHS-41**
Lead Author:	**MH Suicide Reduction Guidance SLWG**
Responsible Director:	**Michael Smith, Lead Associate Medical Director, MHS**
Approved by:	**MHS Quality & Clinical Governance Group**
Date approved:	**Aug 2018**
Date for Review:	**Aug 2021**

Revision/Amendment I n f o r m a t i o n

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0	Sep 2017	New guidance	SLWG for Suicide Reduction Guidance MHS
1.1	Aug 2018	• Basic function of the clinical risk tools in use within GG&C added to the background and introduction • Table of Risk Tools in use across GG&C and guidance location • Table of point of contact, where the tools will be completed and by whom	SLWG for Suicide Reduction Guidance MHS

Contents Page

Appendix A

NHS GG&C Mental Health Service
Emergency Department Mental Health Triage & Risk Assessment Tool

1. Statement

This guidance describes the measures taken by NHS Greater Glasgow & Clyde Mental Health (GG&C MHS) and Substance Misuse Services to minimise the risk of suicide for people using its services.

2. Scope

This guidance applies to all staff working within NHS Greater Glasgow & Clyde Mental Health Services. This includes Adult and Older Adult Mental Health, Learning Disabilities, Alcohol and Drug Recovery Services, Forensic & Child & Adolescent Mental Health Services. This also includes all temporary, bank and agency staff.

3. Background & Introduction

Suicide is a devastating event and Mental Health Services have a duty to ensure that deaths by suicide and other adverse consequences of suicidal behaviour users are prevented wherever possible. Whilst the process of assessment will never completely eliminate risk, identification of potential clinical risk will allow positive steps to be taken to mitigate it.

To help achieve this aim NHS GG&C MHS has developed a suite of policies which will provide a co-ordinated approach to Suicide Reduction. Staff will be expected to apply the principles, actions and procedures set out in the policies that are listed in this document.

Clinical risk is addressed using 3 distinct protocols across NHS GG&C: Acute general staff in Emergency Departments use the Emergency Department Mental Health Triage and Risk Assessment tool, CAMHS staff use Face CARAS and Mental Health Service staff use the Clinical Risk Screening and Management Tool, CRSMT.

The primary objectives for each of the three tools are outlined in the table below:

Tool	Primary Objectives	Guidance/Supporting Policy
FACE Child & Adolescent Risk Assessment Suite (CARAS)	An evidence based risk assessment tool designed and validated to conduct accurate risk assessment for children and young people. It uses a systematic and structured approach to assess relevant static and dynamic factors	FACE CARAS
Clinical Risk Screening & Management Tool (CRSMT)	Establishes a framework and standards for the assessment and management of clinical risk within the overall context of the provision of high quality clinical care. Supports and encourages clinical practice associated with improved outcomes and incorporates learning from Significant Clinical Incidents.	MHS 07 - Clinical Risk Screening and Management Policy

Mental Health Triage and Risk Assessment Tool (MHTRAT)	Provides Emergency Department staff with a systematic framework for the safe and effective triage and medical assessment of people who present with mental health needs. It supports clinical decision making in the management of immediate clinical risk.	

At what points of contact will the tools be completed, by whom?

Point of Contact	Staff completing	Tool Used
Primary Care	GP	No standard tool
Police Custody	GP	No standard tool
Prison Healthcare	GP	No standard tool
PCMHT	CPN/Psychology	CRSMT
Emergency Department	Acute ED Staff	MHTRAT
	Out of Hours/Liaison/Unscheduled care practitioners	CRSMT
	CAMHS staff	Face CARS
Acute General Ward	MH Liaison	CRSMT
	Acute general staff	No standard tool
Community Mental Health Team	MH staff	CRSMT
Crisis/Out of Hours/unscheduled care practitioners	MH staff	CRSMT
MH Inpatient	MDT	CRSMT
Forensic Service	MDT	CRSMT
Addiction Psychiatry Community Addictions Team	NHS Staff	CRSMT
	Social Work Staff	CRSMT
Learning Disability Services	All staff	CRSMT
CAMHS	All staff	Face CARAS

4. High Impact Change Areas

The following 7 areas have been identified alongside the existing NHS GG&C policies as having impact on the overall service/clinical strategy to help reduce or prevent suicide:

4.1 Clinical Risk Management
4.2 Environment of care
4.3 Clinical Observation
4.4 Joint/Interface and Transitions
4.5 Response to self-harm
4.6 Response to incidents
4.7 Data & Information Sharing
4.8 Safe Service Design and Stakeholder Involvement

The Improvement/Implementation Plan describes in more detail the work required for each identified area. The following section highlights safety-critical aspects of relevant polices and guidelines collated in this document.

4.1 Clinical Risk Management

a) Implement the Clinical Risk Screening & Management policy, including appropriate training, documentation and care planning

b) Audit practice against the 5 good practice standards;
   1. Risks are identified, considered and documented at every significant clinical encounter or decision point (including home or clinic visits, MDT and CPA meetings) and at a minimum once per shift for inpatient services
   2. In the community, a structured risk assessment will be completed at initial assessment by the service, at every subsequent transition of care thereafter following a significant clinical incident and as a minimum once per year.
   3. In hospital, a structured risk assessment and safety plan will be completed, implemented and recorded in the case notes within 2 hours of admission and updated within 72 hours and following a significant clinical incident.
   4. Where an inpatient is to be managed at home (including on pass), risks and their management will be discussed with family or carers whenever possible, and their views taken into account before a decision is taken
   5. Everyone will be followed up by a clinician within 7 days of discharge from hospital preferably in person. Where contact is by telephone, the decision not to review face to face is based on risk assessment and will be documented.

c) Standardise the approach to risk assessment and management by Mental Health service staff using electronic structured framework and staff training
d) Recognise the importance of distress as an indicator of suicide risk, and as an opportunity for therapeutic engagement
e) Implement training and updates for all 3 Risk management tools – CRSMT, Face CARAS and Emergency Department Mental Health Triage and Risk Assessment tool
f) Use data to monitor adherence to the risk standards as per policies

And to monitor outcomes

4.2 Environment of Care

a) Implement standard specification of new builds and refurbishments
b) An environmental check of clinical areas will be completed annually to identify 'high risk areas' which are most difficult to supervise – details of frequency and process to be decided.
c) Ensure ligature cutters and suitably trained staff are available in all appropriate areas.
d) Ensure processes are in place to ensure effective communication of risk at unit and team level e.g. handover reports, MDT review meetings, safety huddles and safety briefs

4.3 Clinical Observation

a) Recognition that most incidents occur amongst patients considered to be at "low risk" and the importance of staff awareness, regular patient / staff 1 to 1 interactions, informal checks and interventions in preventing suicide.
b) Ensure adherence to MHS 23 Safe & Supportive Observation Policy & Practice Guidance (MHS 23), emphasising the importance of therapeutic engagement
c) Emphasise the importance of the 'named nurse' and key worker / caseload holder role for engagement and continuity of care for inpatients and interface between wards and community services.
d) Minimise absconding and unplanned absence from the ward.
e) Use data to tack performance in this area

4.4 Joint/Interface working and Transitions including follow-up post-inpatient discharge

a) Recognise the increased risk associated with transitions of care and that about one quarter of suicides occurs within three months of discharge from hospital.
b) Recognise the increase in risk when working across two or more teams. This is particularly important when substance misuse is Present. The Health Improvement Scotland (HIS) 'Reducing suicide Risk' Mental Health Team discussion framework is a useful tool.
c) Recognise the importance of adhering to MH-substance misuse guidance on interface working (MHS 13)
d) Adhere to the policy on the use of Care Programming Approach (CPA) for complex care plans
e) Follow up within 7 days of discharge from hospital

4.5 Response to Self-Harm

a) Recognition of the large increase in risk of completed suicide after presentation with self-harm
b) Recognise the importance of treating people who have self-harmed with compassion and respect
c) Ensure that people who have self-harmed receive a comprehensive psychosocial assessment
d) Ensure that people who have self-harmed have a collaboratively developed risk management plan
e) Ensure that staff have appropriate training in Suicide prevention

4.6 Response to incidents, including immediate actions, incident investigation, family/carers engagement and system learning

a) Importance of debriefing to staff, patient and witnesses after an incident
b) Ensure all family members/carers, as appropriate, are offered the opportunity to raise questions or concerns as part of Significant Clinical Incident reviews (SCIs)
c) Routinely disseminate for information and implement findings from national and local safety learning summaries
d) Keep policies updated in the light of new evidence, guidelines and system feedback – including "near misses" as well as adverse incidents

4.7 Data and information sharing, including disclosures to family/carers

a) Implement the Community Mental Health Operational Framework to recognise the importance of good communication, especially with areas of interface such as primary care and addictions services.
b) Raise awareness with all staff of the importance of involving families/cares whenever possible in suicide prevention — Reference documents:

- Consensus statement on Information sharing and suicide prevention.
- Mental Welfare Commission Good Practice Guide: Carers & Confidentiality

c) Recognise the importance of family and carer roles in identifying and protecting against risks
d) Use data to track performance

4.8 Safe Service Design and Stakeholder Involvement

a) Work without service users and partner organisations through the work streams of the Multi-agency Distress Collaborative. More information on the work of the collaborative can be objected by contacting the Programme Manager – Fiona.McMahon@ggc.scot.nhs.uk
b) Design services and pathways of care with service users and care experience and safety as its core
c) Work with the Suicide Reduction Steering Group for the Board across all agencies and stakeholders, including Public Health and Health Improvement aspects of Suicide Reduction

5. NHS GG&C Mental Health Service Existing Clinical Policies

Within NHS GG&C Mental Health Services there is a managed clinical policy and guideline process which provides a framework for the development, review, approval, distribution and implementation of clinical policies and guidelines across the service. The following NHS GG&C Mental Health Service clinical policies and guidelines have been approved and implemented across the service area and have been identified as having a potential positive impact on Suicide Reduction.

The policies have been set out in the following sections:

5.1 Inpatient Services
5.2 Community Services
5.3 Interface/Joint Working
5.4 Organisational

The key points, content or main aims of each policy has been summarised in the relevant section.

The following links can be used to source a wide range of clinical policies and guidelines within NHS GG&C:

Mental Health Service - Clinical Policies	**NHSGGC Policy Manual**
GGC Clinical Guidelines	

5.1 Inpatient Services

Nine policies have been identified as forming a suite of complementary and relevant policy standards and guidance to aid suicide reduction and which apply to all inpatient areas for Adult and Older Adult Mental Health, Alcohol & Drug Recovery Service, Learning Disabilities and other associated services.

MHS 07 - Clinical Risk Screening and Management Policy (Current**)**

Key points:

- Formalise the use of the NHSGG&C Clinical Risk Screening & Management Tool (CRSMT) and standardise practice and procedures for screening and assessment of clinical risk across the system
- Support professional judgment and a multi-professional approach to the assessment and management of risk
- Set out standards which support the implementation of good practice and provide a platform for audit and supervision.

MHS 15 - Management of Non-Clinical Sharps

Key Points:

- What is needed to maintain a safe environment, the roles and responsibilities for staff when they encounter non-clinical sharps
- The process and procedures to follow when dealing with non-clinical sharps and communication responsibility of staff when dealing with other services or organisations (Police etc)

MHS 18 - Missing Person/Absconsion Policy

Key Points:

- Shared understanding of all the procedures to follow when a service user goes missing from the service
- Agreed standard for practice which allows a systematic approach to local search and knowledge of when to escalate
- The communications process to follow is standardised across GG&C MHS

MHS 19 - Personal & Environmental Search policy

Key Points:

- Promotes a shared understanding of the process & procedures to follow that underpins the person's right to privacy, dignity and respect
- Values base built on positive relationships
- Understanding of the justification for search in a moral and legal framework

MHS 22 - Policy for Locking Doors on Open Wards

Key Points:

- Allows the implementation of the least restrictive practice
- Promotes care tailored to the individual needs
- Applicable only when the person has diminished capacity to understand risk

MHS 23 - Safe & Supportive Observation Policy & Practice Guidance

Key Points:

- Clinicians should be familiar with the definitions of general, constant and special observations
- "Prescribing" observation levels should be done with the same attention to safety and adverse effects as medicines prescribing

For Information:

Most inpatient deaths occur in bedrooms or en suite bathrooms; most deaths occur when patients are on general observations; most deaths occur from 5pm-11pm, or at busy times on the ward, such as handovers in care

MHS 26 - The Co-ordination, Planning & Monitoring of Patient Passes

Key Points:

- Systematic approach to planning and risk assessment of the pass
- Clear agreements between MDT and patient regarding the parameters of the pass involving family/carers as appropriate
- Communication and escalation process if the person fails to return at the agreed time

Please note that within Crisis Service Operational Policy, there are three documents currently listed to reflect the service models within different areas of the organisation.

Community Services Framework

Key Points:

- The safe assessment of people when they come into contact with the service
- Ensure that treatment is delivered promptly with the minimum of fuss or delay
- Prioritise high quality care delivery by well informed, knowledgeable staff

Community Mental Health Teams DNA Guidance

Key Points:

- Optimise attendance at appointments
- Provides guidance and process for service to follow when a person fails to attend one or more schedule appointment
- Identify & manage high risk situations in a systematic and caring manor

MHS 08 – Crisis Service Operational Policy

Renfrewshire Crisis, IHTT Policy

Key Points, the service:

- Responds to people who are experiencing high levels of distress or crisis
- Provides an alternative to hospital admission 24/7
- Provide individualised care and intervention taking into account the persons legal status, emotional state and personal wishes

5.3 Interface/Joint Working

Policies which have an impact and apply across services

MHS 03 - Adult Mental Health & Addiction Services Shared Guidance & Specification for Interface Working

Key points:

- Agreed communication and referrals process between the services
  A defined process for dealing with situations which are deemed to be a psychiatric emergency for people with a dual presentation
- Supports, facilitates and promotes joint working for people with complex co

MHS 43 – Bed Management Policy & Operational Guidance

Key Points:

- Provide a consistent approach to all Mental Health Service in-patient admissions, implementing contingency planning, the use of pass beds, ensuring wherever possible that admissions are facilitated within the geographical locality in-patient wards and to promote safe and effective use of beds.
- The development of local agreed contingency plans
- Provides a clear escalation process when bed availability becomes critical

NHS GG&C Policy on Significant Clinical Incidents

Key points:

- Provides a guide to identifying significant clinical incidents (SCIs) in mental health services (MHS), and conducting an appropriate review.
- Helps the organisation to learn from adverse events, may relieve some of the distress and uncertainty experienced by relatives.

To help all mental health staff, clinical and managerial, to improve the service for others by recognising where risk can be reduced, where clinical practice and service improvements can be made, and also by sharing the good practice and any learning identified

Psychiatric Emergency Plan (PEP)

Key points:

- To promote the implementation of the MH Act (Scotland) 2003
- Gives clear guidance for all staff who may be involved in the detention of patients or in the discharge of any function under the act
- To develop, agree and communicate the shared working practices between different aspects of the service and other agencies (Police, Ambulance, etc.)

To ensure the smooth transition of a person between different parts of the service

NHS GG&C Incident Management Policy

Key points:

- A guide for staff on how to report clinical and non-clinical incidents, including near misses and potential incidents.
- Seeks to encourage a culture of reporting so as to identify and learn from sources of error and risk which may lead to damage, loss or harm, complaint or legal claim for negligence

Promotes understanding and learning from incidents is an important part of risk

Care Programming Approach (CPA Policy)

Key Points:

- Defined referral criteria
- Standard process for referral and defined eligibility criteria
- Standard risk assessment and care planning carried out

6.1 The MHS 07 Clinical Risk Screening & Management Policy will be fully

Implemented and will ensure mandatory staff training with 3 yearly updates.

6.2 Staff will have access to training about the management of patients with substance misuse and mental health problems, in keeping with the policy on joint working with substance misuse services

6.3 All clinical staff will receive training on the use of ligature cutters as part of medical emergency training/ILS.

6.4 All clinical staff have an awareness of missing persons policy and procedure

6.5 All staff are aware of environmental safety issues in their clinical areas.

6.6 All staff have an awareness of risk factors for inpatient suicide including absconding and the importance of MDT decision making around reduction of observation levels.

6.7 All staff has an awareness of the importance of involving the family and patient in decision making where possible, particularly early in an admission, prior to pass or discharge from hospital through 'Triangle of Care' awareness raising through local learning and associated self-assessment and action plans within community and inpatient settings.

6.8 Use of the HIS Reducing Suicide Risk – Discussion framework (2015) may support clinical teams in reviewing their response to suicidal risk.

6.9 There are a number of training courses available within NHS GG&C Mental Health Services which touch on the subject of Suicide Reduction. These courses cover the entire workforce, some tailored at those with no previous experience of the subject and others have a detailed content tailored for frontline staff who are dealing with this subject on a daily basis. Courses include:

- Self-Harm Awareness and Skills:- "What's the Harm" self-harm awareness and skills course
- Choose Life Training
- Inverclyde Making Wellbeing Matter delivery plan incorporating suicide prevention actions
- STORM training

7 Roles and Responsibilities

Responsible Directors

- Ensure that the actions and requirements of the NHS GG&C MHS 41 Suicide Reduction Guidance are followed.
- Ensure that the Mental Health Policy Management System is in place and adhered to with respect to the implementation of the MHS 41 Suicide Reduction Guidance.
- The production of management reports with Clinical Risk and others which provide thematic and trend analysis of suicides and incident data, to inform practice development and organisational learning.
- Ensure the effective investigation of relevant incidents and the system-

Wide application of relevant learning.

Heads of Adult Services/General Managers

- Have operational responsibility for the implementation of this guidance within own areas of management
- Ensure that a system is in place to identify staff training needs prior to the implementation of the MHS Suicide Reduction Guidance.
- Take action to improve the safety and care environment by carrying out routine regular inspections using the agreed checklist and facilitate any necessary remedial action. Any risk assessment is only valid for a point in time or for as long as the risk factors remain unchanged and therefore all staff should be alert to identifying new risks and repeat the assessment when changes are made to the environment.
- Release staff to undertake the applicable mandatory training to their area of service and Clinical Risk Assessment tool in use.
- Communicate lessons learned from incidents for service wide sharing.
- The production of management reports which provide thematic and trend analysis of suicides and incident data, to inform practice development and organisational learning.
- Have responsibility for ensuring the production of SCI investigation reports with action plans to address any identified care and service delivery issues

Mental Health Quality & Care Governance

The Clinical Risk manager will provide an overview of the clinical risk activity across NHS Greater Glasgow and Clyde Mental Health Services in relation to:

- Significant Clinical Incident (SCI) activity
- Any new issues identified by clinical risk team for consideration
- "Avoiding Serious Events Monitoring"
- Mental Health system wide actions

The group will:

- Review the SCI activity and make recommendations on how to manage delays
- Review the system wide actions and identify areas for improvement

Inpatient Service Manager/Community Service Manager

- Review the clinical risk data for their area of responsibility
- Ensure that staff within their area receive any Safety Bulletins and Learning Summaries/learning from adverse events and agree and monitor any local actions required to implement the recommendations
- Take action to improve the safety and care environment by carrying out routine regular inspections using the agreed checklist and facilitate any necessary remedial action. Any risk assessment is only valid for a point in time or for as long as the risk factors remain unchanged and therefore all staff should be alert to identifying new risks and repeat the assessment when changes are made to the environment
- Liaise with the Quality Improvement team and liaise with clinical networks as appropriate to ensure that any practice improvements are implemented within their area.
- Feedback to Quality Improvement forums and clinical networks on any

Improvements initiated within their areas and ensure dissemination of any learning

Senior Charge Nurse/Team Leads/Heads of Department

- Ensure that the MHS 41 Suicide Reduction Guidance is accessible to all staff within their area.
- Ensure that staff within their area have received the MHS 41 Suicide Reduction Guidance and that staff have read and understood their responsibilities.
- Ensure that any revised information, clinical practice changes or amended paperwork is available to staff before the implementation of the guidance.
- Supporting all clinical staff in the Mental Health Service to attend the appropriate training as set out in their organisational training needs analysis.
- Implementation of the systems and processes that are in place to monitor and prevent suicide within this guidance.
- Facilitating the process where all clinical staff is reviewing their caseload, clinical practice on a regular basis within a supervisory framework.
- Monitoring that accurate record keeping within GG&C standards is maintained in collaboration with the service user/patient through the care pathway.
- Support staff by having systems in place to enable staff monitor the functional state of any system that is installed to prevent suicide e.g. Door Alarms.
- Ensuring any adverse incidents or near misses, including those involving ligatures and/ or the use of the Big Fish ligature cutter in an inpatient setting, are reported according to the MHS Incident reporting policies and procedures and investigated accordingly.
- Ensuring the procedure for the safety or, use of and decontamination and maintenance of the cutter is added to local inductions.
- Completion and reflection on the Reducing Suicide Risk - HIS Reducing Suicide Risk – Discussion framework as appropriate

Employees

- Being aware of the content of this guidance and application of the prescribed standards in practice.
- Implementing the guidance standards and procedures.
- Maintaining their individual competence in Suicide Reduction strategies, including clinical risk assessment and clinical risk management and attending training as required by their role.
- Be aware of service users/ patients at increased risk of suicide and to develop and implement care plans appropriate to their individual needs and risks.
- Routinely use the approved Risk Assessment Tool to identify and support the service users/patients that are vulnerable to suicide as part of the care delivery.
- Ensuring any adverse incidents or near misses, including those involving ligatures and/ or the use Big Fish ligature cutter in an inpatient setting, are reported according to the organisations Incident reporting policies and procedures and investigated accordingly.

- Ensuring the procedure for the safe use, decontamination and maintenance of the cutter is added to local inductions
- Ensuring the weekly checks is completed as per the developed weekly checklist.

Resuscitation Service
The Resuscitation Officer is responsible for:

- The development of scenario based training for removal of ligatures and the physical healthcare of patients after the use of a ligature. These scenarios will be part of the Medical Emergency Training (MET) Course offering, on request, advice relating to ligature cutters to managers, inpatient staff and clinical areas; monitoring of the safe use, after use service? and storage of Big Fish ligature cutter
- Developing a system of weekly checks for the cutters, incorporated into existing emergency equipment checks
- Auditing the ward based checking of the placement of the cutters or blades
- Maintaining and updating their own knowledge and skills

8 Implementation

The Suicide Reduction Guidance Improvement/Implementation Work Plan has been developed to ensure that there is a detailed record of the work to be carried out to ensure that the identified High Impact Change areas in section 4 are addressed. This work will be reflective of the implementation of the new policies identified and the range of services, professionals and groups that they cover.

Appendix A

NHS GG&C Mental Health Service
Emergency Department
Mental Health Triage & Risk Assessment Tool

Important Note:
The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Document Number:	
Lead Author:	**Lynne Scott – Associate Chief Nurse – South Sector**
Responsible Director:	
Approved by:	**Quality & Clinical Governance Group**
Date approved:	**13 August 2018**
Date for Review:	
Replaces previous version: [if applicable]	

Revision/Amendment I n f o r m a t i o n

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0	21/02/2018	First Draft for Approval	Lynne Scott C Sellar
	13/08/2018	Approved at Acute Clinical Governance	

Contents Page

1 Policy Statement

The NHS Greater Glasgow and Clyde Mental Health Triage & Risk Assessment Tool (MHTRAT) will be completed for all patients who present to an Emergency Department (ED) or Acute Assessment Unit (AAU)/ Immediate Assessment Unit's (IAU) and have mental health as a feature of their presentation.

This policy aims to:

- Formalise the use of the GG&C MHTRAT and standardise practice and procedures for screening and triage of clinical risks across the GG&C Emergency departments & AAU/IAU's.
- Support professional judgment and a multi-professional approach to the assessment and management of the identified risk.
- Set out standards which support the implementation of good practice and provide a platform for audit and supervision.

2 Scope

The policy applies to the use of the MHTRAT within all emergency departments and assessment units across GG&C and is for use by both nursing and medical staff for patients with mental health as a feature of their presentation.

3 Introduction & Background

This policy and guidance has been developed to support the use of the Mental Health Triage and Risk Assessment Tool (MHTRAT) in practice. The information within this document can be used as a guidance on how to use the tool in practice and provide information about the background and rational for the development of the tool.

The MHTRAT sets out a framework and standards for the triage and medical assessment process for people who present at the Emergency Department with a mental health a feature of their presentation, and supports clinical decision making on the management of immediate clinical risk.

The tool and 'How to Use Guide' was developed in 2011 in collaboration with clinical staff from Acute and Mental Health Services to support clinicians in the Emergency Departments to carry out an assessment of presenting risks which was evidence based, effective and happened in a standardised way.

In 2012 a review of the MHTRAT was carried out as part of the work of the NHS Greater Glasgow and Clyde Mental Health and Acute Interface Group. There were a range of clinicians involved in the review including staff from Emergency Medicine, Mental Health, Drug and Alcohol, Out of Hours and Crisis. The tool was developed further and following a period of review and consultation it was recommended that the MHTRAT be implemented into each of the ED's across NHS Greater Glasgow and Clyde in 2013.

Likelihood that the individual would leave before assessment; and it is those people who were noted to have more risk factors for repeat presentations and completed suicide.

The MHTRAT was developed therefore to support the effective and safe management of patients presenting to the Emergency Department with a mental health presentation, it will help clinicians identify those at higher risk, and will support decision making regarding prioritising care. The development of tool drew upon the published research into the development of similar assessment tools in Australia and in the UK, and on NICE Guideline 16 - *Self-harm; the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*.

4 What is the Mental Health Triage and Risk Assessment Tool

4.1 The Two Part MHTRAT

These are two parts to the MHTRAT and both must be completed:

- **Part 1** is designed to guide the nursing triage process, and to facilitate the recording of the key characteristics of patients presenting with a mental health component to their presentation.
- **Part 2** provides a framework for guiding medical assessment, for documenting relevant clinical features and for informing the clinical decision-making in relation to patients presenting with a Mental Health component to their presentation.

Part 1 – Nursing Triage

It is important that all sections are completed. Based on the information gathered at the point of triage there should be consideration of the following:

- Physical health observations may help to identify co-existing physical health problems and possible problematic drug or alcohol use.
- Parenting or caring responsibilities and contact with children should be taken into account.
- Where the patient is placed within the department. Where the patient is placed within the department should be discussed with a senior person.

1) This would often be within the clinical area and in sight of clinical staff who have been informed that the patient is there and the reasons for this.
2) It may occasionally be appropriate for a patient to be placed in the waiting area if accompanied.
3) This decision will be informed by the risk category identified by the triage nurse. The risk categories are clearly identified as High/ Moderate/Low and are responses to the questions set out in the initial presentation, appearance and behaviour section of the MHTRAT. If there is a yes response to any of the questions in the first column, then the person will be **high** risk. If there is a yes response in the second column and there are no yes responses in the first column then the risk is **moderate**, all no responses to

Each of the questions in the third column is a **low** risk.

- There is not an expectation that all safety risks can be identified as the initial assessment may be based on incomplete information.

Part 2 – Medical Assessment

This part will be completed by ED medical staff. It guides a more detailed mental health assessment and it will:

- Include a current formulation of presenting risks
- Identify the immediate clinical actions in relation to the patient such as referral to specialist mental health services.
- Take into account parenting or caring responsibilities and contact with children.

9 Mental Health Triage and Risk Assessment Tool Standards

5.1.1 The MHTRAT will be completed for people presenting to Emergency Departments where mental health is a feature of their presentation.

5.1.2 The triage and medical assessment should include the patient perspective of risk and the views of significant others. The clinician can listen and take cognisance to what the significant other has to share in relation to the patient history without breaching patient confidentiality, even when the patient has stated that they do not want their details shared.

5.1.3 It is important when completing the MHTRAT that the following are considered and taken into account:

- That the person is able to give consent and they have capacity to be able to engage in the assessment process?
- A person who is a looked after and accommodated child; as they may be at higher risk of self-harm and suicide attempts.
- An older person who has self-harmed should be reviewed by psychiatry.
- An Adult Support and Protection issue?
- An individual who has experienced Gender Based Violence?
- An individual who may require Emergency Psychiatric Detention?

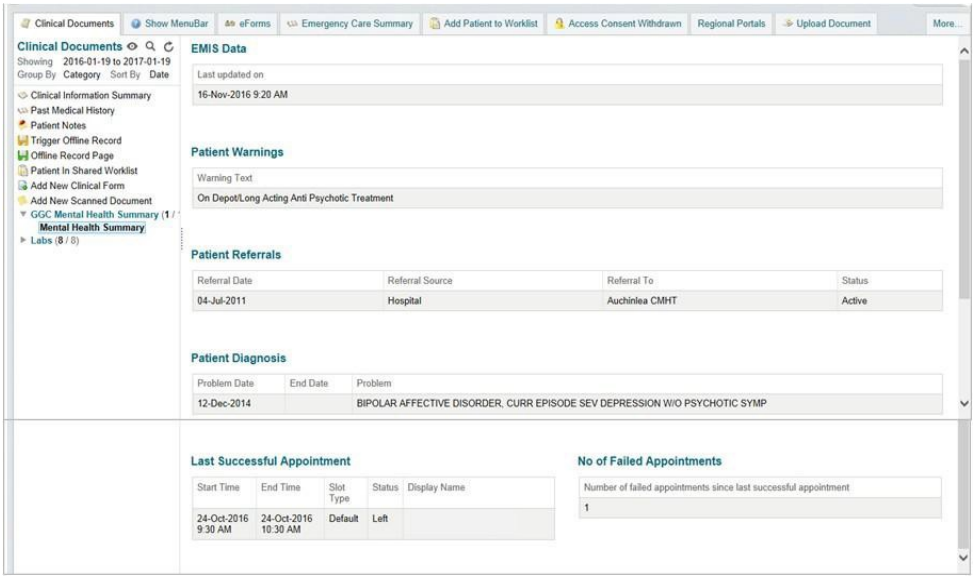
5.1.4 All risk factors must be considered and this includes previous suicidal ideation or attempts, family history of self-harm behaviour or suicide. Other risk factors are mental illness, low self-esteem and experience of someone completing suicide

5.1.5 Protective risk factors to consider includes a strong sense of self-worth and self-esteem, resilience, and the individual can describe reasons for living.

5.1.6 The above list of risks has been given as examples; it is not an exhaustive list but a guide to inform the clinical management of the patient.

5.1.7 It is important to note that the MHTRAT does not have to be completed in isolation and doesn't preclude seeking advice from senior clinical staff.

5.1.8 Where practical, information should be accessed from a number of sources including other healthcare professionals e.g. Liaison Psychiatry and the Mental Health Summary Page, which includes the following information



5.1.9 Throughout the patient's stay within the ED there will be a range of people involved in the patients care. It is important that there is communication between clinicians regarding any identified risks each time the patient is handed over. This will support effective communication, effective risk management and reduce the need for the patient to repeat their story

5.1.10 Before making a referral to metal health services for assessment the MHTRAT should be completed in full. The completed tool should be made available to Mental Health Liaison and Out of Hours (OOH) Community Psychiatric Nurses (CPN) before starting their assessment.

5.2 Clinical Record

- The completed MHTRAT must be kept as part of the patients' clinical record.
- At discharge the notes including the MHTRAT will be scanned and then uploaded to the Clinical Portal. This will be done by Health Records staff.
- If the patient is being transferred to another hospital the MHTRAT and any ED notes should be scanned onto the clinical portal before the notes leave the department. This will ensure there is always a copy of the MHTRAT available even though the patient has been transferred and reduces the risk of the MHTRAT being separated from the clinical record.

5.3 Accessing the MHTRAT

- Copies of the MHTRAT will be available in each of the Triage areas.
- If there are no hard copies of the MHTRAT available staff should access a copy from an agreed source e.g. shared drives.
- The eventual goal is that the MHTRAT will be available electronically on Trakcare

5.4 Audit

- How the MHTRAT is used in practice within ED's, AAU's and IAU's and its use will be audited at monthly intervals with the attached audit tool (appendix 1) Local audits of each ED, AAU & IAU will be carried out monthly.
- This will be carried out within each ED AAU and IAU using the agreed sample size for each area by an identified individual working within the ED.
- The results from local audits will be fed back through Acute Governance structures and local action plans will be developed based on the audit results.

6 Roles and Responsibilities

Below under the specific headings are the expectations of staff as a whole and any specific roles and responsibilities associated with particular posts.

6.1 Responsible Directors

- The development of this policy
- Monitoring adherence to this policy.
- Identifying the training needs associated with this policy.

6.2 Emergency Department, AAU/IAU – Medical & Nursing Staff

- Maintain their level of competence in relation to identifying and managing clinical risks.
- Carry out the mental health triage process.
- Develop and deliver a risk management plan based upon this risk screening process
- Ensure the information contained in the MHTRAT is shared with any onward service for example the Mental Health Out of Hours CPNs

Appendix 1

NHS GGC Mental Health Triage Risk Assessment Tool
Explanatory Notes

Inclusion Criteria
Patients who have attended an Emergency Department in Greater Glasgow and Clyde
Sample should be 20 patients per month (or 5 per week)

Instructions
For each question, a Y for Yes or N for No or a NA for Not Applicable should be entered for each of the 20 patients in the data collection tool.

Question	Explanation	
1	Is there an MHTRAT available in the patients notes	
2	Has the nursing triage been completed fully?	For each subsection of the question, please note Y or N to answer whether the stated section has been completed
3	Do all of the above = Y	There will only be a Y to this question if ALL nursing subsections have been completed
4	Has the medical triage been completed fully?	For each subsection of the question, please note whether the stated section has been completed
5	Do all of the above = Y	There will only be a Y to this question if ALL medical subsections have been completed
6	Do all of the above = Y	There will only be a Y to this question, if ALL medical and nursing subsections have been completed (Y to BOTH questions 3 and 5)